MEDICAL ASSISTANCE ADMINISTRATION

OXYGEN AND RESPIRATORY THERAPY

Billing Instructions

January 2000

(Chapter 388-552 WAC)

About this publication

This publication supersedes all previous MAA Oxygen & Respiratory Therapy Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
January 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

Applying for a provider

Call the toll-free line:
(800) 562-6188

or call one of the following numbers:

(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Where do I call if I have questions regarding…

Policy, payments, denials, or general questions regarding claims processing, Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

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Definitions

This section defines terms, abbreviations, and acronyms used in these billing instructions that relate to the Medical Assistance Program.

By Report (BR) - A method of reimbursement by which MAA determines the amount it will pay for a service that is not included in MAA's published fee schedules. MAA may request the provider to submit a "report", describing the nature, extent, time, effort, and/or equipment necessary to deliver the service.

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Compressor - A pump driven appliance which mechanically condenses atmospheric air into a smaller volume under pressure. In respiratory therapy, it is used to forcefully nebulize liquid solutions or emulsions into a vapor state, or mist for inhalation.

Concentrator - A device which increases the concentration of oxygen from the air.

Department - The state Department of Social and Health Services. (WAC 388-500-0005)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) - A federal report generated by Medicare for providers which provides transaction information on claims submitted to Medicare for payment/processing.

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary services. Managed care involves having clients enrolled:

- With or assigned to a primary care provider;
- With or assigned to a plan; or
- With an independent provider, who is responsible for arranging or delivering all contracted medical care. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment. (WAC 388-552-005)

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance Administration (MAA) - The unit within the department of social and health services authorized to administer the Title XIX Medicaid and the state-funded medical care programs. (WAC 388-500-0005)

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. (WAC 388-500-0005)

Oxygen - USP medical grade liquid oxygen or compressed gas. (WAC 388-552-005)

Oxygen System - All equipment necessary to provide oxygen to a person. (WAC 388-552-005)

Patient Identification Code (PIC) - An alphanumeric code which is assigned to each Medicaid client consisting of:

a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha or numeric character (tie breaker).

Portable Oxygen System - A small system that allows the client to be independent of the stationary system for several hours, thereby providing mobility outside of the residence. (WAC 388-552-005)

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Provider, or Provider of Service -
An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance and Status Report (RA) - A report produced by the claims processing system in the Division of Program Support, Medical Assistance Administration, that provides detailed information concerning submitted claims and other financial transactions.

Respiratory Care Practitioner – A person certified by the Department of Health and employed in the treatment, management, diagnostic testing, rehabilitation, and care of patients with deficiencies and abnormalities which affect the cardiopulmonary system and associated aspects of other systems, and are under the direct order and qualified medical direction of a physician. (Refer to chapter 18.89 RCW and chapter 246-928 RCW)

Revised Code of Washington (RCW) - Washington State laws.

Stationary Oxygen System – Equipment designed to be used in one location, generally for the purpose of continuous use or frequent intermittent use. (WAC 388-552-005)

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual & Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed* 1) the usual and customary charge that you bill the general public for the same services, or 2) if the general public is not served, the rate for the same services normally offered to other contractors.

Ventilator - A device to provide breathing assistance to clients with neuromuscular diseases, thoracic restrictive diseases, or chronic respiratory failure consequent to chronic obstructive pulmonary disease. It includes both positive and negative pressure devices.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

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Oxygen and Respiratory Therapy

What is the purpose of the Oxygen & Respiratory Therapy Program? [Refer to WAC 388-552-001 (1)(a)]

The purpose of this program is to provide medically necessary oxygen and/or respiratory therapy equipment, services, and supplies to eligible Medical Assistance Administration (MAA) clients who:

- Reside at home; or
- Reside in a nursing facility; and
- Who are not enrolled in a managed care plan.

Who should use these billing instructions?
[Refer to WAC 388-552-001 (1)(b) and (2)]

Providers who furnish oxygen and respiratory therapy equipment, supplies, and services to eligible, MAA fee-for-service clients should use these billing instructions. Instructions for clients with Medicare as their primary insurer are covered in Medicare's Durable Medical Equipment Regional Carrier (DMERC) Manual.

Client Eligibility

Who is eligible? [Refer to WAC 388-552-100 (1)]

MAA fee-for-service clients are eligible for oxygen and respiratory therapy equipment, supplies, and services.

Clients with one of the following identifiers on their Medical Assistance IDentification (MAID) card are subject to the following limitations:

Exceptions

- **Emergency Hospital and Ambulance Only** (Medically Indigent Program) –These clients are not eligible for the Oxygen and Respiratory Program.

- **CNP-QMB or MNP-QMB** (Categorically Needy Program/Qualified Medicare Beneficiaries and Medically Needy Program/Qualified Medicare Beneficiaries) **–** The clients are covered by Medicare and Medicaid as follows:

  - ✓ If Medicare covers the service, MAA will pay the lesser of:

    - ➢ The full co-insurance and deductible amounts due, based upon Medicaid's allowed amount; or

    - ➢ MAA's maximum allowable for that service minus the amount paid by Medicare; or

  - ✓ If Medicare denies or does not cover equipment, supplies, or services that MAA covers according to these billing instructions, MAA reimburses at MAA's maximum allowable; however, MAA does not reimburse for clients on the Qualified Medicare Beneficiaries (QMB) Only Program.

Can managed care clients receive oxygen and respiratory therapy services? [Refer to WAC 388-552-100 (2)]

Oxygen and respiratory therapy equipment and supplies are covered services under the client's Healthy Options managed care plan when the services are medically necessary. Clients whose MAID cards have an HMO identifier in the HMO column are enrolled in a Healthy Options managed health care plan.

Provider Requirements

What is my responsibility as an oxygen provider?

(Refer to WAC 388-552-200)

As an oxygen provider, it is your responsibility to:

- Work within your designated scope of practice as outlined in current WAC and RCW.
- Check the client's MAID card to verify that the client is eligible before providing the service. If the client's MAID card has an indicator in the HMO column, contact their managed care plan for all coverage conditions and limits on services.
- Verify that the client's original prescription is signed and dated by an authorized prescriber no more than 90 days prior to the initial date of service. The documentation must include, at a minimum:
  - ✓ The client's medical diagnosis, prognosis, and documentation of the medical necessity for oxygen and/or respiratory therapy, equipment, supplies, and/or services, and any modifications.
  - ✓ If oxygen is prescribed:
    - ➢ Flow rate of oxygen (e.g., 2 liters per minute).
    - ➢ Frequency and duration of oxygen use (e.g., 10 minutes per hour).
    - ➢ Lab values or oxygen saturation measurements upon client's discharge from the hospital: arterial blood gases without oxygen and/or oxygen saturation levels.
    - ➢ Estimated duration of need.
- Make regular deliveries of medically necessary oxygen to the client's nursing facility or private residence.
- Provide instructions to the client and/or caregiver on the safe and proper use of equipment provided.
- Maintain all rental equipment in good working condition on a continuous (24-hour, seven-days-a-week) basis.
- Provide a minimum warranty period of one year for all client-owned medical equipment (excluding disposable/non-reusable supplies).

- **Keep a copy of all warranties in your files and provide them to MAA upon request.** If the warranty expires, information must include the date of purchase and the warranty period.

- Bill MAA your usual and customary fee for clients not in managed care and residing at home or in a nursing facility.

What do I need to do to renew an oxygen prescription?
(WAC 388-552-220)

Oxygen providers must:

- Obtain a renewed prescription every six months if the client's condition warrants continued service; and

- Verify, at least every six months, that oxygen saturations or lab values substantiate the need for continued oxygen use for each client. The provider may perform the oxygen saturation measurements**. MAA does not accept lifetime certificates of medical need (CMNs).**

Notifying Clients of Their Right to Make Their Own Health Care Decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

How MAA's Requirements Differ from Medicare's

MAA's policies on respiratory equipment, services, and supplies are consistent with Medicare's **with the following exceptions**:

Oxygen and Oxygen Equipment

- MAA covers chronic and continuous use of medically necessary oxygen and respiratory therapy equipment and supplies for eligible clients who reside in nursing facilities.

- MAA does not recognize lifetime CMNs for clients who are Medicare/Medicaid eligible and for whom Medicare has denied or stopped oxygen benefits.

- MAA requires logs of oxygen saturations or lab values to substantiate medical necessity for continuous oxygen use at least every six months for all clients.

- MAA covers oxygen for clients 18 years of age or older with $SaO_2 \leq 88\%$ or $PaO_2 \leq 55mm$ on room air and when prescribed by a physician.

- MAA covers oxygen for clients 17 years of age or younger to maintain the level of SaO_2 at:

  - ✓ 92%, or
  - ✓ 94% in a child with cor pulmonale or pulmonary hypertension.

- MAA covers respiratory care practitioners and ventilation therapist services in the client's home. Therapist services are included in the nursing facility per diem for eligible clients residing in nursing facilities.

- MAA allows the provider of the respiratory services to measure oximetry readings for every six-month's renewal.

- MAA pays for six-month maintenance/service checks only on client-owned ventilators and CPAPs.

- MAA does not pay for six-month maintenance/service checks unless the service is actually provided.

Continuous Positive Airway Pressure (CPAP) System
(Refer to WAC 388-552-320)

- MAA allows the rental of a CPAP system for an initial two-month period.
- MAA requires the provider to convert CPAP rentals to a purchase when, at the end of the initial two-month rental period, the attending physician determines that:
  - ✓ The client's apnea is chronic; and
  - ✓ The CPAP is the least costly, most effective treatment modality.

Suction Pumps/Supplies **(WAC 388-552-360)**

- MAA covers suction pumps and supplies when medically necessary for deep oral or tracheostomy suctioning.
- MAA may cover one stationary and one portable suction pump for the same client if warranted by the client's condition. The provider and attending physician must document that either:
  - ✓ [The] travel distance or potential weather conditions could reasonably be expected to interfere with the delivery of medically necessary replacement equipment; or
  - ✓ The client requires suctioning while away from the client's place of residence.

Tracheostomy Care Supplies

- MAA covers tracheostomy holders, neckbands, and ties.
- See the *Fee Schedule* for limitations of items in this section.
- MAA reimburses for gloves, sterile water, suction instruments, etc., when billed by Durable Medical Equipment (DME) providers and pharmacists. To become a DME or pharmacy provider, see the *Important Contacts* section.

Coverage

Stationary Oxygen Systems

What is covered?

- MAA covers **one** payment for stationary oxygen systems, **per month**. MAA considers all of the following as stationary oxygen systems:

  - ✓ Stationary;
  - ✓ Compressed gaseous;
  - ✓ Stationary liquid; or
  - ✓ A concentrator.

- Regardless of how many stationary oxygen systems are required to ensure the client's oxygen needs are met, MAA considers this one monthly fee as payment in full.

Portable Oxygen Systems

What is covered?

- MAA covers **one** payment for portable oxygen systems, **per month**. MAA considers both portable gaseous and portable liquid as portable oxygen systems.

- Regardless of how many portable oxygen systems are required to ensure the client's oxygen needs are met, MAA considers this one monthly fee as payment in full.

Stationary Oxygen Contents

What is covered?

MAA covers a maximum of **one** payment for stationary oxygen contents, **per month**, when both the stationary and portable oxygen systems are owned by the client.

Portable Oxygen Contents

What is covered?

MAA covers a maximum of **one** payment for portable oxygen contents, **per month**, when one of the following is true:

- The client owns a concentrator and owns or rents the portable system; or
- The client uses only a portable oxygen system.

Continuous Positive Airway Pressure (CPAP) and Supplies

What is covered? [WAC 388-552-320 (1)(2)]

- MAA covers the **rental** and/or purchase of medically necessary CPAP equipment and related accessories when **all** of the following apply:
  - ✓ The results of a prior sleep study [polysomnogram] indicate the client has sleep apnea;
  - ✓ The client's attending physician determines that the client's sleep apnea is chronic;
  - ✓ CPAP is the least costly, most effective treatment modality;
  - ✓ The item is FDA-approved; and
  - ✓ The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG).
- MAA covers six-month maintenance checks on client-owned CPAPs.

> ☞ **NOTE:** Use type of service "R" and modifier "MS" to bill MAA. **The service is billable when actually performed.**

- MAA covers the rental of CPAP equipment for a maximum of two months. Thereafter, if the client's primary physician determines the equipment is tolerated and beneficial to the client, MAA will purchase it.

CPAP Accessories and Services that are NOT covered:

MAA does NOT cover accessories/services not specifically identified in the fee schedule in this document.

Ventilator Therapy, Equipment, and Supplies

What is covered? (Refer to WAC 388-552-330 and WAC 388-552-350)

- MAA covers medically necessary ventilator equipment rental and related disposable supplies when **all** of the following apply:

  ✓ There is a prescription for the ventilator;

  ✓ The ventilator is to be used exclusively by the client for whom it is requested;

  ✓ The ventilator is FDA-approved; and

  ✓ The item requested is not included in any other reimbursement methodology such as, but not limited to, diagnosis-related group (DRG). Prescribed medically necessary accessories (such as humidifiers, nebulizers, alarms, temperature probes, adapters, connectors, fittings, and tubing) are included in the monthly rental payments.

- MAA covers a secondary (back-up) ventilator at 50% of the monthly rental, if medically necessary.

  ☞ **NOTE:** You **must** use modifier "**5B**" when submitting a claim for a second ventilator, for the same client, for the same rental period.

- MAA covers the purchase of the following durable accessories for client-owned ventilator systems:

  ✓ Battery charger, replacement;
  ✓ Heavy-duty battery replacement;
  ✓ Battery cables, replacement;
  ✓ Nasal cannula or mask;
  ✓ Tubing;
  ✓ Breathing circuits; and
  ✓ Variable concentration masks.

- MAA covers and requires that one maintenance/service visit every six months for client-owned equipment must be done on client-owned ventilators.

  ☞ **NOTE:** Use type of service "R" and modifier "MS" to bill MAA.

- MAA covers ventilator therapy services when they are prescribed, medically necessary, and provided by a certified respiratory care practitioner.

What is not covered? [Refer to WAC 388-552-350 (3)]

MAA does not reimburse separately for ventilator therapy services provided to clients residing in nursing facilities. This service is included in the nursing facility's per diem.

Infant Apnea Monitor Program

Who may provide Infant Apnea Monitors? [Refer to WAC 388-552-230 (1)]

Oxygen providers that have a respiratory care practitioner or registered nurse with expertise in pediatric respiratory care directing their apnea monitor program may provide these monitors.

Additional Responsibilities of Infant Apnea Monitor Providers [Refer to WAC 388-552-230 (2)(3)]

Infant Apnea Monitor providers must:

- Have a neonatologist's confirming assessment and recommendation as a second opinion in the client's file unless the client's diagnosis is:

  - ✓ Apnea of prematurity;
  - ✓ Primary apnea (e.g., ventilator-dependent infant);
  - ✓ Obstructed airway; or
  - ✓ Congenital conditions associated with apnea (e.g., cardioarrhythmia); and

- Keep all of the following in the client's file:

  - ✓ The prescribing physician's prescription;
  - ✓ Documentation supporting the medical necessity for apnea monitoring;
  - ✓ The estimated length of time an apnea monitor will be needed; and
  - ✓ Regardless of diagnosis, a neonatologist's written clinical evaluation justifying each subsequent rental period.

☞ **NOTE:** Enter the prescribing physician's provider number in field 17a on the HCFA-1500 claim form when billing MAA.

What is covered? (WAC 388-552-340)

- MAA covers infant apnea monitors on a rental basis.
- The initial rental period must not exceed six months.
- MAA includes all home visits for equipment setup, follow-up calls, and training in the rental allowance.

Respiratory Therapy

Scope of Practice **(Refer to RCW 18.89.040)**

- The scope of practice of respiratory care includes, but is not limited to:

  - ✓ The use and administration of medical gases, exclusive of general anesthesia;
  - ✓ The use of air and oxygen administering apparatus;
  - ✓ The use of humidification and aerosols;
  - ✓ The administration of prescribed pharmacologic agents related to respiratory care;
  - ✓ The use of mechanical or physiological ventilatory support;
  - ✓ Postural drainage, chest percussion, and vibration;
  - ✓ Bronchopulmonary hygiene;
  - ✓ Cardiopulmonary resuscitation as it pertains to establishing airways and external cardiac compression;
  - ✓ The maintenance of natural and artificial airways and insertion, without cutting tissues, of artificial airways, as ordered by the attending physician;
  - ✓ Diagnostic and monitoring techniques such as the measurement of cardiorespiratory volumes, pressures, and flows; and
  - ✓ The drawing and analyzing of arterial, capillary, and mixed venous blood specimens as ordered by the attending physician or an advanced registered nurse practitioner as authorized by the board of nursing under RCW 18.88. [1987 c 415 S 5.]

- In addition, MAA expects respiratory therapists to include the following in their visits:

  - ✓ Evaluation of equipment settings for appropriateness in meeting the client's present needs and safety in the client's immediate home environment;
  - ✓ Checks of equipment and assurance that the equipment settings continue to meet the client's needs; and
  - ✓ Communications of concerns or recommendations to the client's physician.

What is covered? **[Refer to WAC 388-552-350 (1)(2)]**

- MAA covers prescribed medically necessary respiratory therapy services in the home.

- The following professional respiratory therapy services must be provided by a certified respiratory care practitioner:

  - ✓ Initial home visit-patient intake and evaluation;
  - ✓ Subsequent home visits, including oximetry services; and
  - ✓ Professional visit for the administration of aerosolized medications.

What is not covered? [Refer to WAC 388-552-350 (3)]

MAA does not reimburse separately for respiratory therapy services provided to clients residing in nursing facilities. These services are included in the nursing facility per diem rate.

Repairs

What is covered?

MAA covers the repair of client-owned non-disposable equipment after the expiration of the warranty period.

What is not covered? [Refer to WAC 388-552-410(2)(c)]

MAA does not cover repairs (including materials and labor) of:

- Equipment or parts under warranty. This includes equipment that was rented and subsequently considered client-owned by MAA;
- Rented equipment; or
- Equipment, when there is evidence of malicious damage, culpable neglect, or wrongful disposition. MAA will not replace such equipment.

How do I get reimbursed for repairs?

Bill MAA using the repair code along with the appropriate units. Keep the following on file and accessible to MAA upon request:

- Actual repair costs;
- Statement of warranty coverage; and
- Date of purchase.

MAA does not reimburse separately for:

- **Telephone calls;**
- **Mileage; or**
- **Travel time.**

These services are included in the reimbursement for other equipment and/or services. [Refer to WAC 388-552-400 (2)]

Miscellaneous Oxygen-Related Durable Medical Equipment (DME)

Does MAA cover oxygen-related DME not specifically addressed in the Fee Schedule?

MAA does cover some oxygen-related DME after medical review. When submitting your claim for miscellaneous oxygen-related DME, you must also fax supporting documentation to:

MAA
Respiratory Program
(360) 586-5299

For your convenience, we have attached a sample fax form at the end of this document. Include the following supporting documentation with your fax:

- Agency name and provider number;
- Client PIC;
- Date of service;
- Name of piece of equipment;
- Invoice;
- Prescription; and
- Explanation of client-specific, medical necessity.

Reimbursement

For clients on Medicare and Medicaid, MAA reimburses providers the coinsurance and deductible. See Durable Medical Equipment Regional Carrier (DMERC) Region D Supplier's Manual for Medicare policies.

Rentals [Refer to WAC 388-552-410 (1)]

- Submit claims for rentals only once a month.
- Rental rates are on a per-month basis, unless otherwise specified.
- Types of rental equipment:

  - ✓ Equipment that normally requires frequent maintenance (such as ventilators and concentrators) is reimbursed on a rental basis for as long as medically necessary; and
  - ✓ Equipment with lower maintenance requirements (such as suction pumps and humidifiers) is reimbursed on a rental basis for a specified rental period, after which the equipment is considered purchased and owned by the client.

- The monthly rental rate includes, but is not limited to:

  - ✓ A full service warranty covering the rental period;
  - ✓ Any adjustments, modifications, repairs or replacements required to keep the equipment in good working condition on a continuous basis throughout the total rental period;
  - ✓ All medically necessary accessories and disposable supplies, unless separately billable according to these billing instructions;
  - ✓ Instructions to the client and/or caregiver for safe and proper use of the equipment; and
  - ✓ Cost of pick-up and delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

In the event of a client's ineligibility, death, or discontinued use of equipment, rental fees must terminate on the last day of eligibility, life, or medically necessary usage. Reimbursement will be prorated in these cases.

Purchases **[Refer to WAC 388-552-410 (2)]**

- Purchased equipment becomes the property of the client.
- MAA reimburses for:

  - ✓ Equipment that is new at the time of purchase. This may be the same equipment that is provided during the initial two-month rental; and
  - ✓ One maintenance visit every six months for client-owned ventilators and CPAPs.

- MAA does not reimburse for:

  - ✓ Defective equipment; or
  - ✓ The cost of materials (and associated labor) covered under the manufacturer's warranty.

- The reimbursement rate for client-owned equipment includes, <u>but is not limited to</u>:

  - ✓ A manufacturer's warranty for a minimum warranty period of one year for medical equipment, not including disposable/non-reusable supplies;
  - ✓ Instructions to the client and/or caregiver for safe and proper usage of the equipment; and
  - ✓ The cost of delivery to the client's residence or nursing facility and, when appropriate, to the room in which the equipment will be used.

- **The provider must make warranty information, including date of purchase and warranty period, available to MAA upon request.**

Owned Respiratory Therapy Equipment
[Refer to WAC 388-552-410 (2)]

- MAA reimburses for only one maintenance and service visit every six months for client-owned ventilators and CPAPs.

☞ **NOTE:** You must use type of service "R" and modifier "MS" when submitting claims for a six-month maintenance check. A six-month maintenance check will be denied unless BOTH type of service "R" and modifier "MS" are used.

- The reimbursement for the six-month maintenance check includes, but is not limited to, all of the following:

  - ✓ Maintaining all equipment in good working condition;
  - ✓ Making any adjustments according to manufacturer's specifications; and
  - ✓ Making any routine cleaning, servicing, and/or repairs as recommended by the manufacturer.

Oxygen System Components

- The monthly reimbursement for stationary oxygen systems includes all of the following:

  - ✓ Oxygen contents;
  - ✓ Tubing;
  - ✓ Regulator;
  - ✓ Flowmeter;
  - ✓ Humidifiers
  - ✓ Administration device (e.g., tracheostomy tube connector);
  - ✓ Hood and/or tent;
  - ✓ Cannula mask; and
  - ✓ Related supplies.

- The monthly reimbursement for portable oxygen systems includes all of the following:

  - ✓ Tubing;
  - ✓ Regulator;
  - ✓ Flowmeter;
  - ✓ Humidifiers;
  - ✓ Administration device (e.g., tracheostomy tube connector);
  - ✓ Hood and/or tent;
  - ✓ Cannula mask; and
  - ✓ Related supplies.

Billing Dates

Providers must bill with **all** dates of service in which the equipment/supplies were used.

☞ **EXAMPLE:** When billing an oxygen system monthly fee for January 2000, dates should be 010100 to 013100.

Nursing Facilities **(Refer to WAC 388-552-390)**

- MAA reimburses for the chronic and continuous use of medically necessary oxygen and oxygen and respiratory equipment and supplies by eligible clients who reside in nursing facilities.

- Do not bill MAA or the client for the following services which are included in the nursing facility's per diem rate:

  ✓ Oxygen and oxygen equipment and supplies used in emergency situations; and

  ✓ Respiratory and ventilator therapy services.

- Nursing facilities with a "piped" oxygen system may submit a written request to MAA for permission to bill MAA for oxygen.

  Send your requests to:

  Professional Reimbursement Section
  Division of Operational Support Services
  Department of Social and Health Services
  PO Box 45510
  Olympia, WA 98504-5510

- Reimbursement for supplies is included in the rental reimbursement for oxygen systems or ventilators, unless otherwise indicated.

Inhalation Drugs & Solutions **(Refer to WAC 388-552-370)**

Inhalation drugs and solutions are included in the Prescription Drug Program. These must be billed only by pharmacists using National Drug Codes (NDCs). To obtain a copy of MAA's Prescription Drug Program Billing Instructions, write to:

Provider Relations Unit
PO Box 45562
Olympia, WA 98504-5562
or call
1-800-562-6188

Oximeters **(Refer to WAC 388-552-380)**

- MAA covers oximeters for clients when they are 17 years of age or younger, in the home, and have one of the following conditions:

  - ✓ **The child has chronic lung disease and is on supplemental oxygen**.
    This child is at risk for desaturation with sleep, stress, or feeding and has a narrow margin for progression to respiratory failure. Weaning off oxygen can more efficiently be done with home oximetry.

  - ✓ **The child has a compromised or artificial airway**.
    This is the child with congenital anomalies, neurodevelopmental compromise, and artificial airways such as nasal stents and tracheostomies. This child is at risk for major obstructive events or aspiration events.

  - ✓ **The child has chronic lung disease requiring ventilator or BiPAP support**.
    Home oximetry is an essential monitoring device for such compromised children as well as for weaning off support, if possible. Children who use BiPAP support are at risk for atelectasis or pneumonia along with their risk for hypoventilation. Early detection of desaturation can provide time to intervene with other measures to avoid severe compromise.

- The provider must review oximetry needs and fluctuations in oxygen levels monthly and log results in the client's records.

Fee Schedule

Notes about the fee schedule

Procedure code description: The description of each procedure code will tell you if:

- A modifier is required.
- A limit applies.
- An item/service is bundled/unbundled.

Maximum Allowance: The *RENTAL* and *PURCHASE* columns indicate the maximum dollar amount or percentage of billed amount payable by MAA. Rentals are calculated on a monthly basis unless otherwise indicated.

Modifiers: **You must use the appropriate modifier with the procedure code when indicated:**

Equipment Rental -	Use modifier "RR"
Equipment Purchase -	Use modifier "1P"
Six Month Maintenance Fee -	Use modifier “MS” (for Ventilators and CPAPs only)
Second Ventilator (Backup) -	Use modifier “5B”

Do Not Bill With: **Any procedure code listed in the “Do Not Bill With” column of the fee schedule is <u>AT NO TIME</u> allowed in combination with the primary code located in the “Procedure Code” column.**

Bill MAA your usual and customary fee (the fee you bill the general public). MAA’s payment will be either your usual and customary fee or MAA’s maximum allowable rate--whichever is lower.

Oxygen and Oxygen Equipment

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Stationary compressed gaseous oxygen system, rental; includes container contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing. 1 unit = 50 cubic ft. **Monthly rental only.** **Limit: 1 per month.** **Modifier RR required.**	**E0424**	**A4615-A4620, E0439, E0441, E0442-E0444 E0550, E1390, E1405, E1406,**	**$195.07**	
Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing. **Monthly rental only.** **Limit: 1 per month.** **Modifier RR required.**	**E0431**	**A4615-A4620, E0434, E0441-E0444, E0550**	**$36.08**	
Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask and tubing. **Monthly rental only.** **Limit: 1 per month.** **Modifier RR required.**	**E0434**	**A4615-A4620, E0431, E0441- E0444, E0550, E0442,**	**$36.08**	
Stationary liquid oxygen system, rental; includes container, contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing. 1 unit = 10 lbs**.** **Monthly rental only.** **Limit: 1 per month.** **Modifier RR required.**	**E0439**	**A4615-A4620, E0424, E0441-E0443, E0550, E1390, E1405, E1406,**	**$195.07**	
Oxygen contents, gaseous (per unit) (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned). **This is a monthly fee.** **Limit: 1 per month.**	**E0441**	**E0424, E0431, E0434, E0439, E0442-E0444, E0550, E1390, E1405, E1406**		**$154.73**

Oxygen and Oxygen Equipment (cont.)

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Oxygen contents, liquid (per unit) (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned). **This is a monthly fee.** **Limit: 1 per month.**	**E0442**	**E0424, E0431, E0434, E0439, E0441, E0443, E0444, E1390, E1405, E1406**		**$154.73**
Portable oxygen contents, gaseous (per unit) (for use with portable gaseous system when no stationary gas or liquid system is used). **This is a monthly fee.** **Limit: 1 per month.**	**E0443**	**E0424, E0431, E0434, E0439, E0441, E0442, E0444**		**$21.47**
Portable oxygen contents, liquid (per unit) (for use with portable liquid systems when no stationary gas or liquid system). **This is a monthly fee.** **Limit: 1 per month.**	**E0444**	**E0424, E0431, E0434, E0439, E0441-E0443**		**$21.47**
Oxygen tent, excluding croup or pediatric tents. **Purchase only.** **Limit: 1 per client.** ***Discontinued for claims with dates of services on and after January 1, 2002.***	**E0455**			**B.R.**
Oxygen concentrator, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate. **Monthly rental only.** **Limit: 1 per month.** **Modifier RR required.** **(Rental includes: humidifier, if needed, cannula or mask and tubing.)**	**E1390**	**A4620, E0424, E0439, E0441, E0442, E0550, E1405, E1406**	**195.07**	
Oxygen and water vapor enriching system with heated delivery. **Monthly rental only.** **Limit: 1 per month.** **Modifier RR required.** **(Rental includes: humidifier, if needed; cannula or mask and tubing.)** ***Discontinued for claims with dates of services on and after January 1, 2002.***	**E1405**	**A4615-A4620, E0424, E0439, E0441, E0442, E0550, E1390, E1406**	**$225.53**	

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Oxygen and Oxygen Equipment (cont.)				
Oxygen and water vapor enriching system without heated delivery. **Monthly rental only.** **Limit: 1 per month.** **(Rental includes: humidifier, if needed; cannula or mask and tubing.)** ***Discontinued for claims with dates of services on and after January 1, 2002.***	**E1406**	**A4615, A4616, E0424, E0439, E0441, E0442, E0550, E1390, E1405**	**$215.23**	

Continuous Positive Airway Pressure System (CPAP)

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Continuous airway pressure (CPAP) device.* **Purchase required after 2 months rental.** **Requires results of sleep study perfprmed in an MAA approved sleep center.** **Limit: maximum of 2 months rental.** **Modifier RR or 1P required.**	**E0601**	**E0452, K0532**	**$114.11**	**$912.88**
Nasal application device used with positive airway pressure device. **(Includes nasal shell or mask, and swivel.)** **Limit: 2 per year.**	**K0183**			**$82.11**
Nasal pillows/seals, replacement for nasal application device, pair. **Limit: 2 per year.**	**K0184**			**$25.16**
Headgear, used with positive airway pressure device. **Limit: 2 per year..**	**K0185**			**$40.61**
Chin strap, used with positive airway pressure device. **Limit: 2 per year.**	**K0186**			**$18.59**
Tubing, used with positive airway pressure device. **Limit: 2 per year.**	**K0187**	**A7010**		**$41.90**
Filter, disposable, used with positive airway pressure device. **Limit: 2 per month allowed.**	**K0188**	**K0189**		**$5.50**
Filter, nondisposable, used with positive airway pressure device. **Limit: 2 per year.**	**K0189**	**K0188**		**$15.66**
Humidifier, nonheated, used with positive airway pressure device.* **Purchase only.** **Limit: 1 per year.** **Modifier 1P required.**	**K0268**			**$109.31**

***For owned ventilators and CPAPs** – Use modifier "MS" and type of service "R" indicator when claiming a six-month maintenance check. Limit of one per six months allowed.
Maintenance checks are paid at 50% of the rental rate.

Continuous Positive Airway Pressure System (CPAP) (cont.)

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g., nasal or facial mask(intermittent assist device with continuous positive airway pressure device) (ie:BiPAP S).* **Requires results of sleep study performed in an MAA approved sleep center.** **Purchase required after maximum of 2 months rental.** **Limit: 1.** **Modifier RR or 1P required.**	**K0532**	**E0601**	**$262.13**	**$3,931.85**

***For owned ventilators and CPAPs –** Use modifier "MS" and type of service "R" indicator when claiming a six-month maintenance check. Limit of one per six months allowed.
Maintenance checks are paid at 50% of the rental rate.

Nebulizers and Accessories

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Nebulizer, with compressor. **Only the following accessories may be billed with this code: A4621 or A7015, A7003-A7006, A7013. Purchase only. When AC/DC adapter is availbe for use with equipment provided, the adapter is considered included in nebulizer reimbursement.** **Limit of 1 per client, per 5 years.** **Modifier 1P required.**	**E0570**	**E0500, E0585**		**$145.34**
Nebulizer, with compressor and heater. **Modifier RR required.** ***Discontinued for claims with dates of services on and after January 1, 2002, use EO570 when billing for nebulizers.***	**E0585**	**E0500, E0570, E1372**	**$30.46**	
Face tent. **Purchase only.** **Limit of 3 allowed per client, per month.** **Modifier 1P required.**	**A4619**	**E1390, E1405, E1406**		**$1.21**
Immersion external heater for nebulizer. **Purchase only.** **Limit: one per 2 years.** **Modifier 1P required.**	**E1372**	**E0585**		**$166.55**
Administration set, with small volume non-filtered pneumatic nebulizer, disposable. **Purchase only.** **Limit: 1 per month.** **Modifier 1P required.**	**A7003**	**A7004**		**$2.80**
Small volume nonfiltered pneumatic nebulizer, disposable. **Purchase only.** **Limit: 3 per month.** **Modifier 1P required.**	**A7004**	**A7003, A7005**		**$1.84**
Administration set, with small volume non-filtered pneumatic nebulizer, non-disposable. **Purchase only.** **Limit: 1 per month.** **Modifier 1P required.**	**A7005**	**A7004**		**$31.49**

Nebulizers and Accessories (cont.)

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Administration set, with small volume filtered pneumatic nebulizer. **Purchase only. Limit: 1 per month. Modifier 1P required. For Pentamidine administration only.**	**A7006**			**$9.75**
Corrugated tubing, disposable, used with large volume nebulizer, 100 feet. **Purchase only. Modifier 1P required. Limit: 1 per month.**	**A7010**			**$24.10**
Corrugated tubing, nondisposable, used with large volume nebulizer, 10 feet. **Purchase only. Modifier 1P required. Limit: 1 per year.**	**A7011**			**$1.49**
Water collection device, used with large volume nebulizer. **Purchase only. Modifier 1P required. Limit: 8 per month.**	**A7012**			**$3.86**
Filter, disposable, used with aerosol compressor. **Only when using E0570. Purchase only. Modifier 1P required. Limit: 2 per month.**	**A7013**	**A7014**		**$.85**
Filter, non-disposable, used with aerosol compressor. **Only when using E0565. Purchase only. Modifier 1P required. Limit: 1 per 3 months.**	**A7014**	**A7013**		**$4.59**
Aerosol mask, used with DME nebulizer. **Purchase only. Modifier 1P required. Limit: 3 per month.**	**A7015**			**$1.92**
Nebulizer, Large Volume, Jet, Humidification for Pulmonary hydration. **Limit: 10 per month.**	**7803E**			**$1.77**

Nebulizers and Accessories (cont.)

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
"Fish" 5cc Saline Vials **Limit: 200 per month.**	**6854E**	**7805E, K0283**		**$.26**
Saline solution per 10 ml, metered dose dispenser for use with inhalation drugs. **Purchase only** **Limit: 72 units per month.**	**A7019**	**6854E, K0283**		**$.35**
Compressor, air power source for equipment which is not self-contained or cylinder driven. **Rental only.** **Only the following accessories may be billed with this code: A4619, A4621, E1372 or 6434E, A7006, A7010-A7012, A7014, A7015 and 7803E.** **Modifier RR required.**	**E0565**		**$52.98**	

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
IPPB Machines and Accessories				
IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source. (Includes mouthpiece and tubing.) **Rental only.** **Modifier RR required.**	**E0500**	**E0570, E0585**	**$95.32**	
Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery. **Rental only.** **Modifier RR required. (Not billable when used with rented ventilator or rented oxygen equipment.)** **Only allowed for IPPB**	**E0550**	**A4615, E0424, E0431, E0434,.E0439 E0450, K0533, E0460, E1390, E1405, E1406**	**$43.53**	

Suction Pump/Supplies

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Tracheal suction catheter, any type, each. **Purchase only.** **Modifier 1P required.**	**A4624**			**$2.69**
Oropharyngeal suction catheter, each (Yankauer). **Purchase only.** **Modifier 1P required.** **Limit: 4 per month.**	**A4628**			**$3.73**
Canister, disposable, used with suction pump, each. **Purchase only.** **Modifier 1P required.** **Limit: 4 per month.**	**A7000**			**$9.75**
Canister, non-disposable, used with suction pump, each. **Purchase only.** **Modifier 1P required.** **Limit: 1 per year.**	**A7001**			**$33.79**
Tubing, used with suction pump, each. **Purchase only.** **Modifier 1P required.** **Limit: 30 per month.**	**A7002**			**$3.91**
Suction pump, home model, portable. **Modifier RR or 1P required.** **Limit: 2 in 5 years, one for use in the home and one for back-up or portahility.** **Deemed purchased after 12 months rental.** **MAA allows payment for suction supplies, (e.g., gloves and sterile water) when billed by Durable Medical Equipment (DME) providers and pharmacists. See Important Contacts section.**	**E0600**		**$46.78**	**$467.80**
Suction pump, home model, stationary. **Purchase only.** **Modifier 1P required.** **Limit: 1 in 5 years.** ***Discontinued for claims with dates of services on and after January 1, 2002, use E0600.***	**6604E**			**$409.94**

Ventilators and Related Respiratory Equipment

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Volume ventilator, stationary or portable, with backup rate feature, used with invasive interface (e.g., tracheostomy tube). (Payment includes all necessary accessories, fittings and tubing.)* **Rental only.** **Modifier RR required.**	**E0450**	**A4611-A4613, A4616-A4618, E0453, E0460, E0550, K0533**	**$828.84**	
Respiratory assistive device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g., nasal or facial mask. (Intermittent assist device with continuous positive airway device). (Bipap ST) (Payment includes all necessary accessories, fittings and tubing.)* **Rental only.** **Modifier RR required.**	**K0533**	**A4611-A4613, A4616-A4618, E0450,E0453 E0460, E0550**	**$656.01**	
Negative pressure ventilator; portable or stationary. (Payment includes all necessary accessories, fittings, and tubing.)* **Rental only.** **Modifier RR required.**	**E0460**	**A4611-A4613, A4616-A4618, E0450, E0453, E0550, K0533**	**$749.39**	
Humidifier heater, with temperature monitor and alarm. (Limited to clients that are mechanically ventilated or clients that have tracheostomies and require heated humidification). **Rental only**. **Modifier RR required.**	**6434E**	**E0424, E0431, E0434,E0439 E0550, E1390, E1405, E1406**	**$181.57**	
Battery, heavy duty; replacement for patient-owned ventilator. **Purchase only.** **Modifier 1P required.** **Limit: 1 per 2 years.**	**A4611**	**E0450, E0453, E0460, K0533**		**$170.58**
Battery cables; replacement for patient-owned ventilator. **Purchase only.** **Modifier 1P required.** **Limit of 1 per 2 years.**	**A4612**	**E0450, E0453, E0460, K0533**		**$78.42**

***For owned ventilators and CPAPs** – Use modifier "MS" and type of service "R" indicator when claiming a six-month maintenance check. Limit of one per six months allowed. Maintenance checks are paid at 50% of the rental rate. **Modifier "5B" and type of service "R" indicator required when claiming a secondary "backup" ventilator for the same client.**

Ventilators and Related Respiratory Equipment (cont.)

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Battery charger; replacement for patient-owned ventilator. **Purchase only. Modifier 1P required. Limit of 1 per 2 years.**	**A4613**	**E0450, E0453, E0460, K0533**		**$147.32**
Cannula, nasal. **For patient-owned equipment. Purchase only. Modifier 1P required. Limit: 2 per month.**	**A4615**	**E0424, E0431, E0434, E0439, E1405, E1406.**		**$1.81**
Tubing (oxygen), per foot. **For client-owned equipment. Purchase only. Modifier 1P required.**	**A4616**	**E0424, E0431, E0434, E0439, E1390, E1405, E1406, E0450, E0453 E0460, K0533**		**$.09**
Mouthpiece. **For client-owned equipment. Purchase only. Modifier 1P required. Limit: 4 per month.**	**A4617**	**E0424, E0431, E0434, E0439, E0450, E0453, E0460, E1390, E1405, E1406, K0533**		**$1.88**
Breathing circuits. **For use with client-owned equipment. Purchase only. Modifier 1P required. Limit: 4 per month.**	**A4618**	**E0424, E0431, E0434, E0439, E0450, E0453 E0460, E1390, E1405, E1406, K0533**		**$7.83**
Variable concentration mask. **For client-owned equipment. Purchase only. Modifier 1P required. Limit: 4 per month.**	**A4620**	**E0424, E0431, E0434, E0439, E1390, E1405, E1406**		**$2.54**
Sterile saline or water, 30 cc vial. **Purchase only. Modifier 1P required. Limit: 1 per day.**	**A4214**			**$1.52**

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Ventilators and Related Respiratory Equipment (cont.)				
Water, distilled, used with large volume nebulizer, 1000ml. **Purchase only.** **Modifier 1P required.** **Limit: 16 per month.**	**A7018**			**$.39**
Water, sterile (1000cc. bottle). **Purchase only.** **Modifier 1P required.** **Limit: 50 per month.**	**A4712**			**$2.68**
Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler (e.g., Aerovent). **Limit: 6 per child, per year; 3 per adult, per year.**	**A4627**			**$23.35**
Percussor, electric or pneumatic, home model. **Purchase only.** **Modifier 1P required. Limit: 1.**	**E0480**			**$448.90**
Flutter valve. **Purchase only.** **Modifier 1P required.** **Limit: 2 per year.**	**6671E**			**$42.40**
Positive Expiratory Pressure Therapy System. Includes: mask (pediatric or adult), valved resistor, detachable monitoring port, tubing and pressure indicator. **Purchase only.** **Modifier 1P required.** **Limit: 2 per year.**	**6894E**			**$37.92**

Tracheostomy Care Supplies

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Tracheostomy cleaning brush, each. **Purchase only.** **Modifier 1P required.** **Limit: 1 per day.**	**A4626**	**7804E**		**$3.26**
Tracheostomy care kit for new or established trach **(includes: basin or tray, trach dressing, gauze sponges, pipe cleaners, cleaning brush, cotton tipped applicators, twill tape, drape, and sterile gloves).** **Purchase only** **Modifier 1P required.**	**7804E**			**$2.76**
Tracheostomy or laryngectomy tube. **Purchase only.** **Modifier 1P required.** **Limit: 1 per client per month.**	**A4622**	**A4623**		**$58.51**
Tracheostomy, inner cannula (replacement only). **Purchase only.** **Modifier 1P required.** **Limit: 1 per client per month.**	**A4623**	**A4622**		**$6.69**
Tracheostomy tube holder, neckband. **Purchase only.** **Modifier 1P required.** **Limit: 15 per month.**	**6510E**	**6442E**		**$3.47**
Tracheostomy ties, each. **Purchase only.** **Modifier 1P required.**	**6442E**	**6510E, A4625, A4629**		**$.69**
Tracheostomy mask or collar. **Purchase only.** **Modifier 1P required.** **Limit: 4 per month.**	**A4621**			**$1.39**
Tracheostomy and ventilator speaking valve. **Purchase only.** **Modifier 1P required.** **Limit: 2 per year.**	**6840E**			**$60.95**

Apnea Monitor and Supplies

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Apnea monitor. **Rental only.** **Maximum of six months rental allowed.** **Modifier RR required.** **Payment includes necessary accessories.**	**E0608**		**$286.40**	
Electrodes (e.g., Apnea monitor), per pair. **Purchase only.** **Modifier 1P required.** ***For use only when client is unable to tolerate carbon patch electrodes.*** **Limit: 15 per month**	**A4556**	**6893E** **E0608** **A4558**		**$10.54**
Conductive paste or gel. **Purchase only.** **Modifier 1P required.**	**A4558**			**$5.31**
Apnea belt kit (includes 2 belts, 4 electrodes, and 4 lead wires). **Purchase only.** **Modifier 1P required.** **Limit: 2 per month.**	**6893E**	**A4556, A4557**		**$25.92**

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Professional Services				
Respiratory therapy initial home visit; patient intake and evaluation. **Allowable one time following a referral, per client.**	**6600E**	**6391E, 6413E, 6450E, 6601E**		**$38.64**
Respiratory therapy home visit: subsequent, includes oximetry services.	**6601E**	**6391E, 6413E, 6450E, 6600E**		**$30.57**
Professional visit for clients on **outpatient aerosolized pentamidine therapy, MUST** be made by a physician, an Advanced Registered Nurse Practitioner (ARNP), a Respiratory Therapist (RT). **Limit: 1 per month.**	**6450E**	**6391E, 6413E, 6600E, 6601E**		**$46.18**
Ventilator therapy initial home visit, patient intake and evaluation. **Allowed one time per provider, per client.**	**6413E**	**6001E, 6391E, 6450E, 6600E**		**$50.80**
Ventilator therapy home visit; billed by any qualified ventilator provider.	**6391E**	**6413E, 6450E, 6600E, 6601E**		**$46.18**
Pneumocardiogram or polysomnogram **(one year of age and under)** service; with recording equipment. **Not to be used on a routine basis. Use only when medically indicated.**	**6616E**			**$152.89**

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Miscellaneous				
Tapes, all types, all sizes. **Purchase only.** **Modifier 1P required.**	**A4454**			**$2.66**
Peak expiratory flow rate meter, hand held. **Purchase only.** **Modifier 1P required.** **Limit: 3 per client, per year.**	**A4614**			**$24.29**
Aerosol effusion bag. **Purchase only.** **Modifier 1P required.**	**6610E**			**$3.08**
Condenser, disposable; each; (e.g., Cascade breathaid artificial noses). **Purchase only.** **Modifier 1P required.** ***Discontinued for claims with dates of services on and after January 1, 2002, use A7509.***	**6612E**			**$3.49**
Filter holder and integrated filter housing, and adhesive, for use as tracheostoma heat and moisture exchange system, each. (Condenser, nondisposable e.g., artificial nose.) **Purchase only.** **Modifier 1P required.**	**A7509**			**$3.56**
Oximeter, complete with all necessary accessories and supplies except probes. **Rental only.** **Modifier RR required.**	**S8105**		**$130.76**	
Oximeter probe/sensor, non-disposable. **Purchase only.** **Modifier 1P required.** **Limit of 1 per month.**	**6437E**			**$179.46**
Oximeter probe\sensor, disposable Purchase only. Modifier 1P required. **Limit: 4 per month.**	**7806E**			**$18.18**
Spirometer; (handheld) non-hospital, disposable. **Purchase only.** **Modifier 1P required.** **Limit: 2 per year.**	**6642E**			**$9.56**

Miscellaneous (cont.)

Description	Procedure Code	Do Not Bill With	1/1/02 Rental	1/1/02 Purchase
Resuscitator bag; non-disposable, adult/pediatric size. **Purchase only.** **Modifier 1P required.** **Limit: 2.**	**6620E**	**6509E**		**$134.11**
Resuscitator bag; disposable, adult/pediatric size. **Purchase only.** **Modifier 1P required.** **Limit: 2.**	**6509E**	**6620E**		**$50.99**
Non-routine replacement parts for equipment repair. **For purchased equipment only**. **Must bill with statement of warranty coverage. See repair policy for documentation requirements.**	**6263E**			**80%**
Repair or non-routine service medical oxygen equipment requiring the skill of a technician, labor component, per 15 minutes. Taxable. **For purchased equipment only**. **Must bill actual repair cost and statement of warranty coverage, see repair policy.**	**6952E**			**$15.76**
Oxygen-related durable medical equipment, miscellaneous. **See miscellaneous oxygen related DME policy before billing this code.**	**7999E**			**BR%**

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Billing

What is the time limit for billing?

State law requires that you present your final bill to MAA for reimbursement no later than 365 days from the date of service. (RCW 74.09.160)

- **For eligible clients:** Bill MAA within 365 days **after** you provide a service(s). Delivery of a service or product does not guarantee payment.

- **For clients who are <u>not</u> eligible at the time of service, but are later found to be eligible:** Bill MAA within 365 days from the Retroactive[1] or Delayed[2] certification period.

- **MAA will not pay if** MAA is not billed within the time limit indicated above. **:**

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

[1] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found to be eligible for the medical services at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for these services.

[2] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Assistance IDentification (MAID) card. An insurance carrier's billing time limit for claim submissions may vary. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the Primary Care Case Managers (PCCM) who referred the client for the services(s). If the client is enrolled in a PCCM plan and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

How do I bill for clients who are eligible for both Medicare and Medicaid?

Some Medicaid clients are also eligible for Medicare benefits. When you have a client who is eligible for both Medicaid *and* Medicare benefits, you should submit claims for that client to your Medicare intermediary or carrier, *first*. Medicare is the primary payor of claims.

Services for Medicaid clients who are enrolled in a managed care plan are billed directly to the managed care plan listed on the clients' MAID card.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and
2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare's allowed amount. MAA will pay up to Medicare's allowable or MAA's allowable, whichever is less.

An **X** in the *Medicare* area on the client's MAID card (area 9) indicates Medicare enrollment.

QMB (Qualified Medicare Beneficiaries) Program Limitations:

QMB with CNP or MNP (Qualified Medicare Beneficiaries with Categorically Needy Program or Medically Needy Program)

- If the client has a CNP or MNP MAID card in addition to the QMB MAID card, and the service you provide is covered by Medicare *and* Medicaid, MAA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.

- MAA will also reimburse for services that are not covered by Medicare but *are* covered under the CNP or MNP program.

QMB-MEDICARE Only

The reimbursement criteria for this program are as follows:

- If Medicare **and** Medicaid cover the service, MAA will pay the deductible and/or coinsurance up to Medicaid's allowed amount.

- If only Medicare and **not** Medicaid covers the service, MAA will pay the deductible and/or coinsurance up to Medicare's allowed amount.

- If Medicare does **not** cover or denies the service, MAA will not reimburse the service.

What must I keep in a client's file?

You must maintain legible, accurate, and complete charts and records in order to support and justify the services you provide.

- **Chart** means a summary of medical records on an individual patient.
- **Record** means dated reports supporting claims submitted to the Washington Medical Assistance Administration for medical services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. Records of service must be kept in chronological order by the practitioner who rendered the service.

For reimbursement purposes, such records must be legible; authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment, or other service to which the entry pertains; and must include, but not be limited to the following information:

1. Date(s) of service.
2. Client's name and date of birth.
3. Name and title of person performing the service, when it is someone other than the billing practitioner.
4. Chief complaint or reason for each visit.
5. Pertinent medical history.
6. Pertinent findings on examination.
7. Quantity of medications, equipment, and/or supplies prescribed or provided.
8. Description of treatment (when applicable).
9. Recommendations for additional treatments, procedures, or consultations.
10. X-rays, tests, and results.
11. Plan of treatment/care/outcome.
12. Oxygen, equipment, supplies, and /or services prescribed or provided.
13. The original and subsequent prescriptions according to the requirements in WAC 388-552-200 and 388-552-220.
14. Logs of oxygen saturations and lab values taken to substantiate the medical necessity of oximetry readings if required by WAC 388-552-380 for a client 17 years of age or younger.
15. Recommendations and evaluations if required by WAC 388-552-230 for the infant apnea monitor program.

Charts/records must be available to DSHS or its contractor and to the U.S. Department of Health and Human Services upon request. DSHS conducts provider audits in order to determine compliance with the various rules governing its medical programs. [Being selected for an audit does not mean that your business has been predetermined to have faulty business practices.]

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing MAA. (The numbered boxes on the claim form are referred to as ***fields***.) Use the instructions below to fill out the HCFA-1500 claim form. **Please enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

DO NOT WRITE, PRINT, OR STAPLE ANY ATTACHMENTS IN THE BAR AREA AT THE TOP OF THE FORM.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the medical assistance ID (MAID) card. This information is obtained from the client's current monthly MAID card consisting of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

FIELD DESCRIPTION

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
3. A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB and would show a **B** indicator in *field 19.*

NOTE: The MAID card is your proof of eligibility. Use the PIC code of either parent if a newborn has not been issued a PIC. Enter indicator **B** in *field 19.*

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related to**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. **Name of Referring Physician or Other Source**: When applicable, enter the referring physician or Primary Care Case Manager name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number of Referring Physician**: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. **Reserved For Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC.*

21. **Diagnosis or Nature of Illness or Injury**: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission**: When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(S) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., January 4, 2000 = 010400).

24B. **Place of Service**: Required. These are the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
4	Client's residence
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)
9	Other

24C. **Type of Service**: Required. Enter a **9** for each item being purchased. Enter an **R** for each item being rented.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. Enter the appropriate HCFA Common Procedure Coding System (HCPCS) procedure code or state-assigned codefor the services being billed. **MODIFIER**: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: For multiple quantities of supplies, enter the number of items dispensed and all of the dates or dates spanned that the supplies were used. Unless the procedure code description specifically indicates pack, cans, bottles, or other quantity, the "each" is each single item.

If billing consecutive days of therapy visits, indicate the number of days (e.g., March 1,2,3,4 = 4) See HCFA-1500 claim form sample.

OXYGEN: Indicate number of units. ***Do not enter the number of days in this space.***

To compute the *units* for oxygen, it is first necessary to convert liters or pounds into cubic feet.

Formula 1: Liter Flow Converted Into Units

(Liter flow/minute x total minutes)
÷ 28.3 = cubic feet

Example:
4-liter flow used for 14 hours, 9 minutes (or 849 minutes)
4 liters x 849 minutes = 3,396 liters
3,396 ÷ 28.3 = 120 cubic feet

Formula 2: Total Pounds Converted Into Units

(Total pounds used) x 12 = cubic feet

Example:
10 lbs. x 12 = 120 cubic feet

For stationary gaseous oxygen:
1 unit = 50 cubic ft.

For portable gaseous oxygen:
1 unit = 5 cubic ft.

For stationary liquid oxygen:
1 unit = 10 lbs.

For portable liquid oxygen:
1 unit = 1 lb.

25. Federal Tax I.D. Number: Leave this field blank.

26. Your Patient's Account No.: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. Total Charge: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. Amount Paid: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not put Medicare payment here or use dollar signs or decimals in this field.

30. Balance Due: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. Physician's, Supplier's Billing Name, Address, Zip Code and Phone #: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N.: Please enter your seven-digit provider number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): JD 020155 SMITH B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JANE D

3. PATIENT'S BIRTH DATE MM DD YY: 02 01 55 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 100 BRIDGEPORT WAY

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98001 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR MARY DOE

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1010101

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 280 .
2. 506 4
3. .
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01	01	00	01	01	00	4	9	E0439	RR	280	27784	1				
2	01	01	00	01	01	00	7	9	E1400	RR	280	27784	1				
3																	
4																	
5																	
6																	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 55568

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 55568

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

RESPIRATORY THERAPY
100 MAIN ST
ANYTOWN, WA 98001

PIN# 9000000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

How to Complete the Medicare Part B/Medicaid Crossover HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide. The numbered boxes on the claim form are referred to as ***fields***. A number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. Use the instructions below to complete the HCFA-1500 form for crossover claims.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, <u>cannot</u> be billed electronically.

The Medicare/Medicaid billing form (HCFA-1500) must be submitted to MAA, Claims Processing Office:

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

General Instructions

- Use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- All information must be centered within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the HCFA-1500 claim form.
- Attach complete, legible Medicare EOMB or claim will be denied.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the Medicaid Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card consisting of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tie breaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

NOTE: The MAID card is your proof of eligibility.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the Medicaid client. **Sex**: Check **M** (male) or **F** (female).

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.
9b. Enter the other insured's date of birth.
9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(S) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., January 4, 2000 = 010400).

24B. **Place of Service**: Required. Enter the appropriate number below:

Code Number	To Be Used For
4	Client's residence
7	Nursing facility (formerly ICF)
8	Nursing facility (formerly SNF)

24C. **Type of Service**: Required. Enter a **9** for purchase or an **R** for rental.

24D. **Procedures, Services or Supplies CPT/HCPCS**: Required. **Coinsurance and Deductible**: Enter the total combined and deductible for each service in the pace to the right of the modifier on each detail line.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: For multiple quantities of supplies, enter the number of items dispensed and all of the dates or dates spanned that the supplies were used. Unless the procedure code description specifically indicates pack, cans, bottles, or other quantity, the "each" is each single item.

OXYGEN: Indicate number of units. ***Do not enter the number of days in this space.***

To compute the *units* for oxygen, it is first necessary to convert liters or pounds into cubic feet.

24K. **Reserved for Local Use**: Required. Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: ***Required***. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Enter the supplier's *Name, Address,* and *Phone #* on all claim forms. Enter your seven-digit provider number here.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

MEDICARE CROSSOVER

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): JD 020155 SMITH B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): SMITH, JANE D

3. PATIENT'S BIRTH DATE MM DD YY: 02 01 55 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 100 BRIDGEPORT WAY

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98001 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01	01	00	01	01	00	4	9	E0431	RR	492.8	6421	1				51.37
2	01	01	00	01	01	00	7	9	E1401	RR	492.8	34730	1				277.84
3																	
4																	
5																	
6																	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 41151

29. $ AMOUNT PAID: 32921

30. $ BALANCE DUE: 8230

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

RESPIRATORY THERAPY
100 MAIN ST
ANYTOWN, WA 98001

PIN# 9000000 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Justification for use of 7999E Miscellaneous Procedure Code

★Fax this form when the claim (bill) has been sent to MAA

Attn: Respiratory Program **Fax: 360 586-5299** ***Also fax: Your Invoice and Client Prescription***

Agency Name: _____ Agency Provider #: _____

Client Name: _____ Client PIC: _____

Client Diagnosis: _____

Date of Service: _____ Name of the Equipment: _____

Medical Necessity: _____

_____

Date of Service: _____ Name of the Equipment: _____

Medical Necessity: _____

_____

Date of Service: _____ Name of the Equipment: _____

Medical Necessity: _____

_____

Date of Service: _____ Name of the Equipment: _____

Medical Necessity: _____

_____

For MAA USE ONLY

Decision: ☐ Approved ☐ Denied Not Medically Necessary ☐ Alternate Code suggested _____		
Description _____, Payment per Unit _____, Total Payment _____		
Logged Date:		Need to establish code: ☐ Yes ☐ No